CHAPTER V—USE OF FUNDING IN SUBSTITUTE CARE

5.01 Introduction

Medicaid waiver funds may be used to provide services to eligible persons residing in waiver allowable substitute care settings, including Adult Family Homes, CBRFs, RCACs and Children's Foster Care/Treatment Foster Care Homes (see Chapter II, Section 2.07 for additional details). The use of Medicaid waiver funds in substitute care settings is regulated by federal law, Wisconsin Statutes and DHFS Administrative Rules. Specific service definitions, requirements and provider standards are described in the applicable standard program category pages in Chapter IV of this manual.

5.02 Determining Waiver Allowable Costs in Substitute Care

Federal law prohibits the use of Medicaid waiver funds for room and board costs. Waiver agencies must be able to show that the waiver costs incurred for those participants residing in substitute care do not include room or board expenses. Because the use of Medicaid waiver funds is prohibited, some or all of the room and board costs are paid by the waiver participant. When the room and board costs exceed the participant's available resources, another source of funding, other than Medicaid waiver dollars, must be used. Below is an overview of substitute care costs that are allowed or are not allowed to be paid by the waivers. Forms and instructions used to determine substitute care costs are located in Appendix J of this manual.

A. Waiver Allowable Costs – Care and Supervision

Medicaid waiver funds may be used to pay costs for care and supervision services provided to participants residing in the facility. Some examples of costs related to care and supervision include staff salaries and health insurance costs/benefits, travel, administrative overhead, staff/agency liability insurance as well as staff development and education materials. For a more detailed breakdown of allowable care and supervision costs, see Appendix J.

B. Non-Waiver Allowable Costs – Room and Board

The substitute care provider is responsible for the determination of the rate for their facility and for providing a breakdown to the waiver agency which identifies facility-specific costs attributed to room and board. The waiver agency is responsible for assuring that such methodology is in place when the agency contracts with a substitute care provider. Documentation identifying the facility costs for room and board must be kept on file at the agency and should be updated at least annually to assure the facility costs are accurate and allowable.

Certain facility expenses may be included as room and board costs. Facility costs that are room and board cannot be paid for by the Medicaid Waiver program. Examples include certain insurance premiums, maintenance costs, food, furnishings, and utilities (This is a partial list of examples only. Please see Appendix J.) County agencies may use the CBRF Model Contract or, the model form Calculating Expenses for a Substitute Care Facility, or another approved methodology to determine room and board costs. The Bureau approved methodology must fairly allocate room and board costs to all residents (see Appendix J).

C. The Special Housing Amount

Participants who reside in substitute care settings may be eligible for the special housing amount deduction in the calculation of the personal maintenance allowance. The CM/SSC determines the **rent** portion of the room and board costs in the facility. To calculate **rent**, subtract the costs for the resident's **food, telephone** and **cable television** from the resident's room and board total. The remainder is the **rent** amount. The CM/SSC provides the calculated **rent** amount to the ESS who calculates the Special Housing Amount deduction using CARES.

5.03 Determining the Participant's Ability to Pay for Room and Board

The participant's contribution toward the cost of room and board in substitute care arrangements is closely linked with financial eligibility for waiver programs. The Financial Eligibility and Cost Sharing Worksheet (DDE 919) or the CARES **ECSC and** ECED screens should be completed prior to determining a waiver participant's ability to contribute toward room and board.

For all waiver eligible persons who reside in a substitute care living arrangement, the DDE-920 must be used to determine the amount of income available to pay room and board. Using financial information from the DDE 919 or CARES, the CM/SSC completes the DDE 920 (see instructions in Appendix J). The form shall be completed upon entering a substitute care living arrangement and reviewed at each annual recertification. Whenever the participant's financial situation changes the form shall be updated. Completed form shall be filed in the participant record together with other recertification documents.

When completing the DDE 920, the monthly amount of discretionary income (line 2) may not be less than $65 and represents the discretionary income retained by the participant. Discretionary income remains the property of the participant and may not be designated to any planned services. The amount on line 15 of the form is the maximum amount the participant may be charged for room and board in the living arrangement. If the participant's maximum obligation is less than the actual room and board rate, the balance of the facility room and board costs may be paid with COP[1], Community Aids or other funds.

[1] COP funds may not be used to pay for RCAC services.

If the participant's maximum obligation is greater than the actual room and board rate, that is, if there is an excess of participant income (regardless of source) after the room and board costs are calculated, the excess represents additional discretionary income that is retained by the participant. Participants residing in substitute care who have a cost share obligation must continue to pay that cost share amount toward a waiver allowable service.

Note: The participant may not be charged for care and supervision services (see Chapter IV, Section 4.07 for additional details).

If a waiver participant is a recipient of SSI-E and lives in substitute care, it must be documented that s/he has exceptional support needs to justify the E Supplement. The room and board, personal needs and community services not covered by a funding source must equal or exceed the SSI-E service/need standard amount in order to apply for the E Supplement for the individual living in substitute care.

5.04 Waiver Specific Requirements: CIP 1A/1B, BIW and CLTS

A. Use of Funds in Children's Group Homes

Department policy and the CMS approved Waivers prohibit the use of a Children's Group Home as a residence for any child. Children using these waivers may not reside in a Group Home of any size. There is no process to make an exception to this regulation. Residential Respite care may be provided in a Group Home to any child using any of the waivers covered in this manual.

B. Use of CIP 1A, 1B and BI Waiver Funds in CBRFs[2]

1. The CIP 1A, CIP 1B and BI Waivers CBRF Variance Requirement

No waiver participant may reside in a CBRF licensed for five and up to eight beds unless the county applies for and receives approval for a variance. Any variance approval applies to the waiver participant and not the facility. This means that variances are not transferable to other individuals either currently served by the facility or who might be served in the future. All variances must be time-limited and other conditions of approval may be imposed. No variance request will be granted in situations where the proposed residence is structurally connected to another facility and the total licensed bed capacity in the combined facilities exceeds eight. A variance may be granted for any one of the following four reasons:

[2] Wisconsin is awaiting approval from the Federal CMS to remove the requirement for variance. Waiver agency staff should contact their assigned CIS for additional details.

a) Needs of the Individual:

A variance may be granted if the individual has needs which can be most effectively addressed by the particular provider because the provider has specialized expertise or offers other unique services, staff or facilities in the geographic area where the person wants to live.

For example, a variance request may be appropriate if there is a CBRF that specializes in the care of individuals with Prader-Willi Syndrome and this is the only specialized provider in that county.

However, if such a living arrangement is not essential for the individual or if the individual's needs cannot be adequately met in the larger setting requested, the variance request may be denied or approved with conditions and limitations imposed.

b) Relocation Deadline:

A variance may be granted if the county must relocate an individual from an institution in a short period of time due to the impending closure of the institution and an appropriate smaller and/or less restrictive facility or natural home is not immediately available and cannot be developed in a timely way. For these variances, time limitations on the duration of the variance will be imposed.

c) High Cost of Care:

A variance may be granted if at any time after the approval of the person's initial service plan, the cost of serving the individual in a smaller residence rises because of changed service needs, is substantially greater than the cost of the 5-8 bed facility and the county lacks the resources to fund the person's plan at the higher cost. A high cost of care variance may also be granted if at any time after the approval of the initial service plan, the cost of serving the person in a smaller residence rises to the threshold for termination of Waiver services described in Chapter II, Section 2.09 (A) (1). The variance will be granted if the use of the larger facility would avoid termination or institutionalization.

d) Waiver Participant Choice:

A variance may be granted if the person or the guardian requests a CBRF provider so long as the cost of this provider is not more than the cost the county would incur if other providers not requiring a variance were used. In this circumstance, the county must provide evidence that the participant or the guardian was given information needed to make an informed choice.

2. CBRF Variance Request, Approval and Process Requirements

To make a request for a variance for CIP IA, CIP IB or BI Waiver participants to enable them to reside in CBRFs, the county agency must submit the following information to the assigned CIS in writing:

a) The reason(s) for the requested variance using one of the listed reasons contained in Section B-1 above.

b) A narrative description of the situation of the Waiver participant who is the subject of this variance request.

c) If the request involves the needs of the individual, describe these and the reasons why this provider and setting is the best option and the efforts made to secure alternatives.

d) If the county faces a relocation deadline, describe the time frames involved in the closure or downsizing of the subject facility, the number of other prospective Waiver participants from that county and the efforts made to secure alternatives.

e) If the request involves high cost issues, please explain and document these in sufficient detail to justify the variance.

f) If the request involves participant choice, include locally developed materials that indicate that the participant and the guardian were informed of alternatives and made this choice with the full knowledge of these. This document must be signed by the participant and guardian (as appropriate), contain a description of the specific alternatives mentioned and describe the process used to inform the participant and guardian of the alternatives.

g) A description of smaller residential settings used in the county's provider network, the county staff who are typically available to recruit and or solicit other kinds of providers who might be considered (such as the adult family home coordinator) and specific fiscal or other barriers to the use of a smaller setting.

h) A description of the proposed CBRF including size, location, staffing numbers and pattern, other people living in the facility, the typical weekly schedule of activities and any special skills or abilities found in the staff of the facility.

i) A description of specific strategies the facility uses to enhance individualization and social integration and how it addresses the limitations associated with larger settings and a plan to mitigate the limitations.

3. Criteria for Approval of Variance Requests for CBRFs

   Variances will be granted if the request meets all of the submission requirements in section one and two above and presents adequate justification for the request in light of the reason offered.

4. Exception to Approval

   Even when a request meets all other criteria previously listed, no request may be granted in situations where the proposed residence is structurally connected to another facility and the total licensed beds in the combined facilities is greater than eight.

5.05 Waiver Specific Requirements: CIP II/COP-W

A. Maximum Amount of Funds Used for CBRF Care

Lead agencies must establish a limit to the amount of the annual allocation for COP/COP-W (including federal COP-W matching funds) that will be spent for community based services to participants who reside in CBRFs (s.46.27(3)(f) Wis. statutes.) The lead agency shall establish a separate such limit for participants in CIP II. (Community based services include all services funded by COP/COP-W or CIP II). The county determined maximum amount is to include expenses in all types of CBRFs, including those comprised of independent apartments and those with a dementia care program.

The limits may be expressed either as a specific dollar amount or as a percentage of the allocations, and shall be incorporated into the county COP Plan, subject to approval by the Interagency Long Term Support Planning Committee. Whenever COP is used as match for any other Medicaid waiver program for a person residing in a CBRF, only the COP funds are counted in the expenditure total.

If a county is at or above the applicable limit, reimbursement for CBRF services may not be provided to any additional applicant unless an exception has been granted by the Department according to HFS 73.10. To request an exception, the agency must file an application approved by its long-term support planning committee in which the agency documents that:

- The applicant has been diagnosed as terminally ill by a physician and hospice services can be provided in the CBRF, and
- The CBRF meets appropriate licensing and size criteria, and
- The CBRF is the person's preference.

Exceptions end under any of the following circumstances:

- The participant no longer resides in the facility where the exception was granted.
- The facility can no longer meet the participant's needs.
- The lead agency can accommodate the cost of services to the participant within its limit on funding for services for residents of CBRFs.

B. Conditions for the Use of CIP II/COP-W in CBRFs

1. Facility Size

   A waiver agency may use CIP II or COP-W funds to provide services to a person residing in a CBRF of **up to 20 beds**. Facilities larger than 20 beds may be used if a variance is granted by the Department (see Section 5.05 E below).

2. Placement Criteria

   Subject to size requirements, CIP II/COP-W funds may be used to provide services to a person residing in a CBRF if certain criteria are met. The list below is a summary of the criteria. The complete policy/process is described in DDE-Memo Series 2002-25 (See Appendix J)

   a) The waiver agency has demonstrated that **all five criteria** below have been met. The **five criteria** include:

      (1) The completion of a pre-admission assessment or consultation prior to admission, regardless of the person's ability to pay,

      (2) A determination that in-home care services are infeasible,

      (3) A determination that the CBRF is the person's preferred residence,

      (4) A determination that the CBRF provides a quality environment and quality care services,

      (5) A determination that the CBRF is cost-effective when compared to other residential options.

   b) The five conditions listed above do not apply if :

      (1) The facility consists entirely of independent apartments (see Section C below); or

(2) The applicant/participant has an irreversible dementia and the facility has dementia programming and meets size requirements (See Section D below.)

Note: Counties may establish more restrictive conditions for CBRF use. See Appendix J for a more detailed description of the five conditions.

C. Independent Apartment CBRFs

Independent Apartment CBRFs entirely consist of apartments with separate lockable access and egress, and with kitchen, bathroom, sleeping, and living areas. Independent apartment CBRFs are waiver allowable settings, regardless of size, under SPC 506.63. Funding may be used in facilities designated by the Department of Health and Family Services, Division of Disability and Elder Services, Bureau of Quality Assurance as consisting entirely of independent apartments. Definitions relevant to this service include:

1. "Bathroom" means a separate room within an apartment accessed by a door within the dwelling unit, and that is useable by the resident in a safe manner and contains a fixed basin and a shower or a tub with hot and cold running water, and a flush toilet, all in proper operating condition. The bathroom shall not be shared with other apartments.

2. "Kitchen" means a room or area within an apartment that is useable by the resident in a safe manner and contains suitable space and equipment to store, prepare and serve foods in a sanitary manner. A kitchen must contain: a cooking stove with at least 2 burners or a built-in cook top or a microwave oven; a refrigerator with a freezer of appropriate size for the number of residents; and a kitchen sink with hot and cold running water.

3. "Separate kitchen, bathroom, sleeping and living areas" means identifiable and useable facilities which may be located within a single habitable room, except for the bathroom which shall always be enclosed and accessed by a door within the dwelling unit. Together these form a complete dwelling unit.

4. "Separate lockable entrance and exit" means individual dwelling unit entry and exits, as required in number, size, type and location by building code, under the control of the resident(s) of the apartment.

5. "Independent apartments" means separate and complete dwelling units, each with separate lockable entrance and exit, and for which rent is paid and the premises are occupied by a single family, including a single individual, or household of not more than two unrelated adults and their children, in accordance with a written lease or admissions agreement covering a period not less than 30 days.

This term shall not include any type of housing in which sleeping accommodations are provided, but toileting or cooking facilities are shared by more than one family or household.

6. "Entirely consists of independent apartments" means that there are only complete dwelling units on the premises in addition to any public and common space features such as lobby, community recreation, laundry, mail, kitchen and congregate dining areas.

Important: Independent Apartment CBRFs shall not be located within the same building as a facility providing skilled or intermediate nursing care. Nor shall such a CBRF be physically connected to a nursing facility except by common service units for laundry, kitchen or utility purposes. Such CBRFs may only offer temporary shelter or respite care for less than 30 days in a number of apartments not exceeding one per 50 apartments of licensed capacity.

D. Funding a CBRF for a Person with Dementia

1. In order to use waiver funding for a person with dementia and be exempt from the five criteria (see 5.05 B above) the person must have a diagnosis of Alzheimer's disease or a related dementia and reside in a facility which has dementia programming. To determine if the facility has dementia programming, the following criteria must be used:

   a) The facility is licensed as a Community Based Residential Facility by the Department of Health and Family Services, Division of Disability and Elder Services, Bureau of Quality Assurance under Wisconsin Administrative Code, HFS 83; and
   b) The CBRF is designated as an Alzheimer's facility as determined by licensure and program statement (HFS 83.07(2)(a)5.a.); and
   c) Staff members receive resident group specific training in dementia care (in accordance with HFS 83.14(1)(a-d)); and
   d) Staff members provide activity programming for persons with irreversible dementia (HFS 83.33(4) (h), 1-7).

Note: A size variance is required if the dementia facility is larger than 20 beds.

E. Use of Funding in CBRFs with more than 20 Beds

Medicaid home and community-based waivers are in-home care programs, created to provide an alternative to institutional care. As CBRFs get larger, they are more likely to operate like or feel like an institution. For example, building safety and design standards that must be met are more institutional, privacy may be reduced, schedules and routines are designed around staffing patterns rather than resident preferences, and so forth.

The Department recognizes that some large CBRFs have designed their facilities and programming to be consumer focused, respectful of the individual, offer privacy and autonomy, and meet needs individually or in small familiar groups. Therefore, if the county lead agency can document that a facility has compensated for the effects of large scale congregate living, the Department may grant a variance to size limitations.

1. COP, COP-W or CIP II funds cannot be used in CBRFs with more than 20 beds unless one of the following applies:

   a) The facility consists entirely of independent apartments. Meeting the criteria for independent apartments constitutes Department approval of the facility and a size variance is not required.

   b) The Department has approved a variance, requested by the county COP lead agency, to provide waiver funding for a specific facility. The variance request has documented how the facility design, environment and programming mitigate the effects of living in a large congregate setting.

2. Lead agencies are not required to purchase services or seek a variance to purchase services from any CBRF for which a size variance is required.

Note: Medicaid does not cover personal care in CBRFs with more than 20 beds (HFS 107.112 (4)) even if a COP/COP-W/CIP II funding variance is granted for the facility.

F. Variance Requests for Use of Funding in CBRFs with more than 20 Beds

1. Counties seeking a variance to the size limitation for particular facilities shall describe all of the following in the variance request:

   a) A narrative of how the facility design and programming are such that the facility is non-institutional that includes the facility floor plan and photographs.

   b) A description of the CBRF efforts to provide services in a manner that enhances resident dignity, independence, privacy and choice, and that mitigates the effects of large, congregate living buildings.

   c) If the variance is requested for a facility that provides services to persons with an irreversible dementia, the request shall contain documentation provided by the CBRF that it is able to accommodate the special needs of these persons. This documentation may include the facility program statement, descriptions of the activity program and a description of staff training.

2. Variance requests shall be reviewed and approved by the county's Long Term Support Planning Committee prior to submission to the Department. Ideally, members of the committee will visit the facility before approving the request. Documentation of committee approval must be sent with the variance request. This may be included in the cover letter or in actual copies of committee meeting minutes.

   If a county intends to contract with a facility for which another agency has received a variance, the county must seek approval of the local Long Term Support Planning Committee as prescribed above and submit a request to the bureau as described below.

3. Lead agencies are to submit requests for variances to use funding in CBRFs with more than 20 beds to the Bureau of Long-Term Support (BLTS). The Bureau will consult with the Regional Human Service Area Coordinator, the Ombudsman, or the Bureau of Quality Assurance as needed.

Note: Department approved person-specific variances are no longer required.

5.06 Contracting for Substitute Care Services

A. Purchasing services in a substitute care facility

In order to purchase services in a substitute care facility using COP or Medicaid waiver funding, the county agency must have a contract with the provider. These contracts are subject to all of the provisions related to contracting for services, including applicable audit requirements, found in s.46.036 Wis. Statutes and in the Allowable Cost Policy Manual as published by the Department.

The Department has developed a model contract that county agencies may use when purchasing services in CBRFs. The CBRF model contract may also be employed when contracting with RCACs and adult family homes. Copies of the model contract can be obtained from the Department of Health and Family Services, Division of Disability and Elder Services, Bureau of Long Term Support.

B. Funding Substitute Care Costs During Resident Absence

Federal regulations prohibit the use of Medicaid waiver dollars for substitute care costs while the participant resides in a hospital, a nursing home or an ICF-MR/ FDD. The following are suggested methods counties may use to address such costs.

1. Use non-Medicaid funds such as COP to cover the costs of support and supervision that would have been reimbursed with waiver funds.

2. Build the costs into the rate. For example, if CBRF residents spend an estimated 20 days a year in hospitals or nursing homes, the annual waiver allowable support and supervision expenses may be averaged over 345 instead of 365 days per year.

3. Build the costs into the rate at any time during the year, make adjustment monthly, or make adjustments at the end of the year to reflect actual costs.

There is no required methodology for utilizing any of the above options other than conforming to acceptable accounting practice and assuring that waiver billing conforms to the requirement to address actual units of service provided monthly per participant.